CHAPTER 22

HEALTH BENEFIT PLANS

Authority

N.J.S.A. 17:1-8.1, 17:1-14, 17:1-15c, 17:1-15e, 17:29B-1 et seq., 17B:30-13.1, 17B:30-23 et seq. and 26:2J-15b; and P.L. 2009, c. 113.

Source and Effective Date

R.2006 d.199, effective April 26, 2006.
See: 37 N.J.R. 3779(a), 38 N.J.R. 2499(b).

Chapter Expiration Date

In accordance with N.J.S.A. 52:14B-5.1c, Chapter 22, Health Benefit Plans, expires on October 23, 2013. See: 43 N.J.R. 1236(a).

Chapter Historical Note

Chapter 22, Health Benefit Plans, was adopted as R.2000 d.452, effective November 6, 2000. See: 32 N.J.R. 2860(a), 32 N.J.R. 4014(a).

Subchapter 1, Prompt Payment of Claims, was adopted as new rules by R.2001 d.13, effective January 2, 2001. See: 32 N.J.R. 1985(a), 33 N.J.R. 105(a).

Subchapter 3, Electronic Receipt and Transmission of Health Care Claims, was adopted as new rules by R.2001 d.364, effective October 1, 2001. See: 33 N.J.R. 750(a), 33 N.J.R. 3461(a).

Subchapter 4, Organized Delivery Systems, was adopted as new rules by R.2002 d.336, effective October 21, 2002. See: 34 N.J.R. 20(a), 34 N.J.R. 3607(a).

Subchapter 5, Minimum Standards for Network-Based Health Benefit Plans, was adopted as new rules by R.2003 d.419, effective November 3, 2003. See: 34 N.J.R. 3485(a), 35 N.J.R. 5116(a).

Subchapter 6, Exclusions and Preauthorization Requirements, was adopted as new rules by R.2004 d.80, effective February 17, 2004. See: 35 N.J.R. 2396(a), 36 N.J.R. 958(a).

Subchapter 7, Carrier/Provider Joint Negotiation Agreements, was adopted as new rules by R.2004 d.295, effective August 2, 2004. See: 35 N.J.R. 5036(a), 36 N.J.R. 3553(a).

Chapter 22, Health Benefit Plans, was readopted by R.2006 d.199, effective April 26, 2006. See: Source and Effective Date. See, also, section annotations.

Subchapter 8, Health Insurance Identification Cards, was adopted as new rules by R.2009 d.333, effective November 2, 2009 (operative July 1, 2010). See: 40 N.J.R. 6527(a), 41 N.J.R. 4117(b).

Subchapter 5, Minimum Standards for Network-Based Health Benefit Plans, was renamed Minimum Standards for Health Benefit Plans, Prescription Drug Plans and Dental Plans by R.2009 d.265, effective September 8, 2009 (operative September 8, 2010). See: 40 N.J.R. 6915(a), 41 N.J.R. 3302(b).

In accordance with N.J.S.A. 52:14B-5.1b, Chapter 22, Health Benefit Plans, was scheduled to expire on April 26, 2013. See: 43 N.J.R. 1203(a).

Subchapter 9, Maternity Installment Payments, was adopted as new rules by R.2011 d.190, effective July 5, 2011. See: 43 N.J.R. 146(a), 43 N.J.R. 1533(a).

CHAPTER TABLE OF CONTENTS

SUBCHAPTER 1. PROMPT PAYMENT OF CLAIMS

11:22-1.1 Purpose and scope

(a) This chapter implements N.J.S.A. 17B:30-26 through 34, which sets standards for the payment of claims relating to health benefit plans and dental plans.

(b) This chapter applies to any insurance company, health service corporation, medical service corporation, hospital service corporation, health maintenance organization, dental service corporation and dental plan organization that issues health benefit plans or dental plans in this State; any organized delivery system; and to any agent, employee or other representative of such entity that processes claims for such entity.

Amended by R.2003 d.446, effective November 17, 2003.
See: 35 N.J.R. 2394(a), 35 N.J.R. 5292(a).
In (b), inserted "any organized delivery system;" following "dental plans in this State;".

11:22-1.2 Definitions

(a) The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise.

"ADR" means alternate dispute resolution.

"Agent" means any entity, including a subsidiary of a carrier, or an organized delivery system as defined by N.J.S.A. 17:48H-1 with which a carrier has contracted to perform claims processing or claims payment services.

"Capitation payment" means a periodic payment to a health care provider for his services under the terms of a contract between the provider and a carrier, under which the provider agrees to perform the health care services set forth in the contract for a specified period of time for a specified fee, but shall not include any payments made to the provider on a fee-for-service basis.

"Carrier" means an insurance company, health service corporation, hospital service corporation, medical service corporation or health maintenance organization authorized to issue health benefits plans in this State and a dental service corporation or dental plan organization authorized to issue dental plans in this State.

"Commissioner" means the Commissioner of Banking and Insurance.

"Claim" means a request by a covered person, a participating health care provider, or a nonparticipating health care provider who has received an assignment of benefits from the covered person, for payment relating to health care services or supplies or dental services or supplies covered under a health benefits plan or dental plan issued by a carrier.

"Clean claim" means:

1. The claim is for a service or supply covered by the health benefits plan or dental plan;

2. The claim is submitted with all the information requested by the carrier on the claim form or in other instructions distributed to the provider or covered person;

3. The person to whom the service or supply was provided was covered by the carrier's health benefits or dental plan on the date of service;

4. The carrier does not reasonably believe that the claim has been submitted fraudulently; and

5. The claim does not require special treatment. For the purposes of this subchapter, special treatment means that unusual claim processing is required to determine whether a service or supply is covered, such as claims involving experimental treatments or newly approved medications. The circumstances requiring special treatment should be documented in the claim file.

"Covered person" means a person on whose behalf a carrier offering the plan is obligated to pay benefits or provide services pursuant to the health benefits or dental plan.

"Covered service or supply" means a service or supply provided to a covered person under a health benefits or dental plan for which the carrier is obligated to pay benefits or provides services or supplies.

(d) If a carrier offers providers access to claims status via an automated telephone system, and the available information includes the date of receipt of the claims, and that information is made available within the timelines established in (a)2 above, the posting of that information shall constitute acknowledgement of receipt of those claims.

Amended by R.2003 d.279, effective July 7, 2003.
See: 34 N.J.R. 2365(a), 35 N.J.R. 2899(a).
Rewrote the section.

11:22-1.4 Claim submission requirements

A carrier or its agent shall notify its participating health care providers at least annually, and shall make available to covered persons on request, a listing of the type of information and documentation that must be submitted with a claim, including a standard claim form and any other claim submission requirements utilized by the carrier for both manually and electronically submitted claims. Carriers or their agents may change the required information and documentation as long as participating health care providers are given at least 30 days prior notice of the change in the requirements. Carriers or their agents shall also supply participating health care providers with a street address where claim submissions can be delivered by hand or registered/certified mail.

11:22-1.5 Prompt payment of claims

(a) A carrier and its agent shall remit payment of clean claims pursuant to the following time frames:

1. Thirty calendar days after receipt of the claim where the claim is submitted by electronic means or the time established for the Federal Medicare program by 42 U.S.C. § 1395u(c)2(B), whichever is earlier; or

2. Forty calendar days after receipt of the claim where the claim is submitted by other than electronic means.

(b) Carriers and their agents shall pay claims that are disputed or denied because of missing information or documentation within 30 or 40 calendar days of receipt of the missing information or documentation, as applicable, pursuant to (a) above.

(c) Payment of a claim shall be considered to have been made:

1. On the date a draft or other valid instrument equivalent to payment was placed in the United States mail in a properly addressed, postpaid envelope; or

2. If not paid pursuant to (c)1 above, on the date of delivery of a draft or other valid instrument equivalent to payment.

(d) A carrier or its agent shall maintain an auditable record of when payments were transmitted to health care providers or covered persons whether by United States mail or otherwise.

Amended by R.2003 d.279, effective July 7, 2003.
See: 34 N.J.R. 2365(a), 35 N.J.R. 2899(a).
In (a)2, deleted "Written claims are considered received based on the U.S. mail postmark date." following the first sentence.

11:22-1.6 Denied and disputed claims

(a) A carrier or its agent shall either deny or dispute a claim, in full or in part, that has not been processed according to N.J.A.C. 11:22-1.5. If only a portion of a claim is disputed or denied, the carrier or its agent shall remit payment for the uncontested portion in accordance with N.J.A.C. 11:22-1.5. The pending of a claim does not constitute a dispute or denial. The carrier or its agent shall, within 30 or 40 calendar days of receipt of the claim, whichever is applicable, notify both the covered person, when he or she will have increased responsibility for payment, and the provider of the basis for its decision to deny or dispute, including:

1. The identification and explanation of all reasons why the claim was denied or disputed;

i. If a claim is denied because it cannot be entered into the claims system, then all reasons why the claim cannot be entered into the claims systems shall be included.

ii. Examples of reasons why a claim cannot be entered into the claims system include: group not covered on date of service; employee/dependent not covered on date of service; non-payment of premium; missing data fields; missing or incorrect data (for example, CPT code, date of service, provider name); and ineligible provider.

iii. If the reasons why a claim cannot be entered into the claims system are subsequently cured and the claim is entered, the carrier's first review after the claim is entered shall identify all applicable reasons for any denial or disputed claim.

iv. A carrier or its agent shall not deny or dispute a claim for reasons other than those identified in the first review after the claim is entered, unless information or documentation relevant to the claim is received after the first review and such documentation leads to additional reasons to deny or dispute which were not present at the time of that review.

2. Where missing information or documentation is a reason for denying or disputing a claim, the carrier or its agent shall provide notice to the provider within the timeframes and in the manner required by P.L. 2005, c. 352;

3. If the amount of the claim is disputed, an explanation of the reason for the dispute, including any change of coding performed by the carrier and the reasons for such change of coding; and

4. The toll free telephone number for the carrier or its agent who can be contacted by the provider or covered person to discuss the claim.

(b) If a carrier or its agent denies or disputes a claim in whole or in part and fails to provide the notice required by (a) above, within the timeframes and in the manner required of carriers that are subject to P.L. 2005, c. 352 the claim shall be deemed to be overdue.

(c) If the carrier or its agent fails to pay a clean claim within the time limits set forth in N.J.A.C. 11:22-1.5, the carrier shall include simple interest on the claim amount at the rate of 10 percent per year and shall either add the interest amount to the claim amount when paying the claim or issue an interest payment within 14 days of the payment of the claim. Interest shall accrue beginning 30 or 40 days, as applicable, from the date all information and documentation required to process the claim is received by the carrier. The carrier may aggregate interest amounts up to $25.00, with the consent of the provider.

(d) If a carrier subject to the provisions of N.J.S.A. 17:33A-1 et seq. has reason to believe that the claim has been submitted fraudulently, it shall investigate the claim in accordance with its fraud prevention plan established pursuant to N.J.S.A. 17:33A-15 or, if applicable, refer the claim to the Office of the Insurance Fraud Prosecutor in the Department of Law and Public Safety.

(e) Unless otherwise provided by law, every carrier or its agent shall pay the amount finally agreed upon in settlement of all or part of any claim not later than ten working days from either the receipt of such agreement by the carrier or the date of the performance by the covered person or the provider of any conditions to payment set forth in the agreement, whichever is later.

(f) Carrier adjustments to claims previously paid shall be based only on actual identifiable error(s) in the submission, processing or payment of a particular claim(s), and shall not be based on extrapolation, with the following exceptions:

1. Where the extrapolation, including the method, is non-binding;

2. In judicial or quasi-judicial proceedings, including arbitration;

3. In governmental administrative proceedings;

4. Where relevant records required to be maintained by the provider have been improperly altered or reconstructed, or a material number of such records are unavailable; or

5. Where there is clear evidence of claim fraud or abuse by the provider.

Amended by R.2002 d.222, effective July 15, 2002.
See: 33 N.J.R. 3239(a), 34 N.J.R. 2455(a).
Rewrote (a)1; in (c), inserted "issue an interest payment" preceding "within 14 days" and added the last sentence.
Amended by R.2003 d.279, effective July 7, 2003.
See: 34 N.J.R. 2365(a), 35 N.J.R. 2899(a).
Rewrote the section.
Amended by R.2003 d.328, effective August 4, 2003.
See: 34 N.J.R. 2950(a), 35 N.J.R. 3557(a).
Added (f).
Petition for Rulemaking.
See: 39 N.J.R. 3419(a), 4004(b), 5378(a).
Petition for Rulemaking.
See: 41 N.J.R. 899(a), 1528(b).
Amended by R.2010 d.144, effective July 6, 2010.
See: 41 N.J.R. 2762(a), 42 N.J.R. 1396(a).
Rewrote (a)2 and (b).

11:22-1.7 Prompt payment of capitation payments

(a) Payment of a capitation payment to a health care provider shall be deemed to be overdue if not remitted to the provider on the fifth business day following the due date of the payment in the contract, if:

1. The health care provider is not in violation of the terms of the contract; and

2. The health care provider has supplied such information to the insurer as may be required under the contract before payment is to be made.

(b) An overdue payment shall include simple interest on the amount of the payment at the rate of 10 percent per year and shall add the interest amount to the payment when it is made.

11:22-1.8 Internal and external appeals

(a) Every carrier shall establish an internal appeals mechanism to resolve disputes between carriers or their agents and participating health care providers relating to payment of claims but not including appeals made pursuant to N.J.A.C. 8:38-8.5 through 8.7 and 8:38A-3.6 and 3.7. The internal appeals mechanism shall be described in the participating provider contract.

1. The internal review shall be conducted by employees of the carrier who shall be personnel other than those responsible for claims payment on a day-to-day basis and shall be provided at no cost to the provider.

2. The internal review shall be conducted and its results communicated in a written decision to the provider within 10 business days of the receipt of the appeal. The written decision shall include:

i. The names, titles and qualifying credentials of the persons participating in the internal review;

ii. A statement of the participating provider's grievance;

iii. The decision of the reviewers' along with a detailed explanation of the contractual and/or medical basis for such decision;

iv. A description of the evidence or documentation which supports the decision; and

v. If the decision is adverse, a description of the method to obtain an external review of the decision.

(b) Every carrier shall offer an independent, external ADR mechanism to participating health care providers to review adverse decisions of its internal appeals process.

1. The ADR mechanism shall be through an independent party. The costs of the process shall be borne equally by the parties. The recommended decision of the ADR mechanism shall be issued no later than 30 business days from receipt by the ADR firm of all documentation necessary to complete the review.

2. The ADR mechanism, including the method to submit a claim through such mechanism, shall be described in the participating provider contract and in the final internal decision denying or disputing the participating health care provider's claim, in full or in part.

3. The decision of the ADR mechanism shall be nonbinding unless the parties agree otherwise.

(c) Carriers shall annually notify participating providers in writing of the internal appeals process and the ADR mechanism and how they can be utilized.

(d) Carriers shall annually report, in a format prescribed by the Department, which includes the number of internal and external provider appeals received and how they were resolved.

Amended by R.2003 d.279, effective July 7, 2003.
See: 34 N.J.R. 2365(a), 35 N.J.R. 2899(a).
In (c), substituted "Life & Health Actuarials" for "Office of Enforcement and Consumer Protection"; in (d), substituted "annually" for "maintain and make available at the request of the Department, the annual provider".
Administrative correction.
See: 35 N.J.R. 3558(a).

11:22–1.9 Reporting requirements

(a) A carrier or ODS shall report to the Department on the timeliness of claims payments in the format set forth in Appendix A to this subchapter, incorporated herein by reference, on a quarterly basis, and on the reasons for denial and late payment of claims in the format set forth in Appendix B to this subchapter, incorporated herein by reference, on an annual and quarterly basis. Instructions for these documents are provided in subchapter Appendix A–1 and Appendix B–1, respectively, incorporated herein by reference. Due dates for the reports are as follows: May 15 for the first quarter; August 15 for the second quarter; November 15 for the third quarter; and March 31 for the fourth quarter in Appendix A and the annual report for Appendix B.

(b) The annual report on the reasons for denial and late payment of claims shall be audited by a private auditing firm at the expense of the carrier or ODS. The annual report shall be accompanied by the report of the auditing firm that reviewed the report. In addition to the Department, copies of the audited annual report shall be sent to the Governor and the majority and minority offices of the Legislature.

(c) The report shall be submitted to the Department by the due date to:

New Jersey Department of Banking and Insurance
Life & Health Actuarial
Prompt Payment Reports
20 West State Street
PO Box 329
Trenton, New Jersey 08625–0329

(d) Reports shall be submitted in hard copy and as an Excel spreadsheet by one of the following media:

1. CD–ROM;

2. Zip diskette; or

3. Floppy diskette.

(e) A carrier or ODS may request an exemption from the requirements to have the annual report required by (b) above audited and to submit a report of the auditing firm. This exemption must be obtained on an annual basis. Such an exemption may be granted if the carrier or ODS meets the following conditions:

1. The carrier or ODS must file the annual Appendix B report required by (a) above in a timely manner. The report shall be accompanied by a request for exemption from the requirements that the report be audited and that a report of the auditing firm be submitted;

2. The carrier or ODS shall have filed the four quarterly Appendix A reports required by (a) above in a timely manner, unless the carrier or ODS was exempted from such filing pursuant to (g) below; and

3. The annual premiums earned by the carrier or ODS in New Jersey for all health benefits plans as defined in N.J.A.C. 11:22–1.2 were less than $5 million in the year covered by the annual report for which the exemption is requested. The carrier or ODS shall provide, in its request for exemption, a reconciliation of these premiums to the net earned premiums for "health benefit plans" as defined at N.J.A.C. 11:4–23A.2 and as reported to the Commissioner pursuant to N.J.A.C. 11:4–23A.8(a)1. The $5 million limit shall be applied on a consolidated basis for companies under common control.

(f) After the Commissioner has reviewed the annual report and the request for exemption, the Commissioner shall either grant or disapprove the request. Any request meeting the conditions of (e) above shall be deemed granted 30 days after its receipt by the Commissioner unless disapproved. The Commissioner may disapprove a request for one or more of the following reasons:

1. The request does not meet the enumerated conditions of (e) above;

2. The carrier or ODS has not filed a report, made a refund, or paid an assessment required by law applicable to a carrier or ODS; or

3. The Commissioner finds that an audit is necessary to verify the accuracy of the report or to otherwise meet the purposes of N.J.A.C. 11:22–1.9 and N.J.S.A. 17B:30–12 et seq.

(g) A carrier or ODS which has obtained an exemption from filing an audited annual report under (e) and (f) above shall also be exempt from filing quarterly Appendix A and B reports for the year following the year for which the exemption was obtained. If the carrier or ODS seeks an exemption from filing an audited annual report for the year following the year for which such an exemption was previously obtained, a separate request for an exemption shall be required for the audited annual report for that ensuing year.

Administrative correction.
See: 35 N.J.R. 3558(a).
Amended by R.2003 d.446, effective November 17, 2003.
See: 35 N.J.R. 2394(a), 35 N.J.R. 5292(a).
Rewrote the section.

11:22–1.10 Remediation/penalty

(a) Upon review of the reports required by N.J.A.C. 11:22–1.9, the Commissioner may require that the carrier or ODS, at its own expense:

1. Implement a plan of remedial action; and/or

2. Have the claims processing procedures of the carrier or its agent be monitored by a private auditing firm for a period to be determined by the Commissioner.

(b) The Commissioner may impose a civil penalty of not more than $10,000 upon the carrier, to be collected pursuant to "the penalty enforcement law," N.J.S.A. 2A:58–1 et seq., if, following the remediation measures in (a) above, the Commissioner determines that:

1. An unreasonably large or disproportionate number of eligible claims continue to be disputed, denied or not paid in accordance with the time frames in N.J.A.C. 11:22–1.5; or

2. A carrier, ODS or the agent of a carrier or ODS has failed to pay interest as required pursuant to N.J.A.C. 11:22–1.7.

Amended by R.2003 d.446, effective November 17, 2003.
See: 35 N.J.R. 2394(a), 35 N.J.R. 5292(a).
In (a), inserted "or ODS" following "the carrier"; in (b), substituted "A carrier, ODS or the agent of a carrier or ODS" for "A carrier or it's agent" preceding "has failed".

health care professional licensed pursuant to Title 45 of the Revised Statutes; a hospital and other health care facility licensed pursuant to Title 26 of the Revised Statutes; and/or a purveyor of prescription, pharmaceutical products or durable medical goods or equipment.

"Health care transaction" or "transaction," for purposes of this subchapter only, means the exchange of information between two or more parties to carry out the financial and administrative activities related to coverage under a health benefits or dental plan, including, but not limited to, health claims and equivalent encounter information, health care payment and admittance advice, health claims status, enrollment and disenrollment in a health plan, eligibility for a health plan, health or dental plan premium payments, first report of injury, deferral certification and authorization and health care attachments.

"Health insurance coverage" means benefits consisting of medical care, provided directly, through insurance or reimbursement, or otherwise, and including items and services paid for as medical care, under any hospital or medical expense policy or certificate or health maintenance organization contract offered by a health benefit payer. The following shall constitute excepted benefits:

1. Coverage only for accident or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit-only insurance; coverage for on-site medical clinics; and other similar insurance coverages, as specified by Federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits;

2. Benefits provided under a separate policy, certificate or contract of insurance, or otherwise not an integral part of the group health plan benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof, and such other similar, limited benefits as are specified by Federal regulation;

3. Benefits offered as independent, noncoordinated benefits, hospital indemnity or other fixed indemnity insurance; and

4. Benefits offered as a separate insurance policy, certificate or contract of insurance, Medicare supplement insurance as defined under Section 1882(g)(1) of the Federal Social Security Act (42 U.S.C. § 1395ss(g)(1) and coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code (10 U.S.C. § 1071 et seq.), and similar supplemental coverage provided in addition to coverage under a group health plan.

"Small Employer Health Benefits Plan" means, for purposes of this subchapter only, any plan identified as such by N.J.S.A. 17B:27A-17 or a "small health plan" pursuant to 45 CFR § 160.103.

"Standard" means a prescribed set of rules, conditions, transaction sets or requirements concerning classification of components, specification of materials, performance or operations, or delineation of procedures, in describing products, systems, services or practices.

"System" or "system for the electronic receipt and transmission of health care claim information" means that electronic network established in accordance with 42 U.S.C. §§ 1320d et seq. for the transaction of health care related information including:

1. Health claims or equivalent encounter information, including institutional, professional, pharmacy and dental health claims;

2. Enrollment and disenrollment in a health plan;

3. Eligibility for a health plan;

4. Health care payment and remittance advice;

5. Health care premium payments;

6. First report of injury;

7. Health claim status; and

8. Referral certification and authorization.

Amended by R.2004 d.460, effective December 20, 2004.
See: 36 N.J.R. 1282(a), 36 N.J.R. 5913(a).
In "Health benefit payer", amended the N.J.A.C. reference; added "Health insurance coverage".
Amended by R.2006 d.200, effective June 5, 2006.
See: 37 N.J.R. 4169(a), 38 N.J.R. 2501(a).
Inserted definition "Clearinghouse".

11:22-3.3 Standard enrollment/change request forms and application/change request forms

(a) 45 C.F.R. 162.1101, Subpart K, the Health Care Claims or Equivalent Encounter Information Standard, and 45 CFR 162.1501, Subpart O, the Enrollment and Disenrollment in a Health Plan Standard, are adopted by the Department, in consultation with the Department of Health and Senior Services, as the electronic standard format for enrollment, disenrollment and claim forms, and are incorporated and made a part herein by reference.

(b) The UB-92, HCFA 1450 (the uniform claim for use by health care institutions and facilities) and the HCFA 1500 (the uniform claim for health care providers) are recognized and adopted by the Department, in consultation with the New Jersey Department of Health and Senior Services, as the paper standard format for claims by medical institutions, facilities and providers. These forms are located at the website maintained by the Federal Health Care Financing Administration (www.hcfa.gov/forms/) and incorporated herein by reference.

(c) The paper standard formats for a universal enrollment/change request form and application/change request form for health insurance coverage are located at subchapter Appendix Exhibits 1A and 1B and are incorporated herein by reference.

(d) Subchapter Appendix Exhibit 3, incorporated herein by reference, is designated as the standard paper claim format to be used for all dental benefit claims.

(e) Payers may add a company name and logo to these standard paper forms.

Amended by R.2004 d.460, effective December 20, 2004.
See: 36 N.J.R. 1282(a), 36 N.J.R. 5913(a).
Rewrote (c).

11:22-3.4 Timetable and operational status reports

(a) On or before October 1, 2002, health benefit payers shall use the standard electronic claim and enrollment forms adopted at N.J.A.C. 11:22-3.3(a).

(b) On or before March 30, 2002, health benefit payers shall file with the Department the First Operational Status Report, in the form set forth in subchapter Appendix Exhibit 2 incorporated herein by reference, demonstrating that they will be capable of implementing the timetable established in (a) above or will be requesting an extension of time pursuant to N.J.A.C. 11:22-3.5.

(c) On or before July 28, 2002, health benefit payers shall file an Interim Operational Status Report in the form set forth in Appendix Exhibit 2 in which the payer shall report that:

1. It expects to comply with the timetable established by this subchapter; or

2. It encountered unexpected delays and may not comply with the timetable. In such circumstances, the payer shall:

i. Explain the cause of the delay;

ii. Provide an estimate of when compliance will be achieved; and

iii. Explain why the delay was not anticipated when the First Operational Status Report was filed pursuant to (b) above.

(d) On or before October 1, 2002, all health benefit payers shall file the Final Operational Status Report in the form set forth in Appendix Exhibit 2, which certifies the then current status of the payer's system for electronic receipt and transmission of standard health care claims and enrollment forms pursuant to (a) above.

(e) If, at the time the Final Operational Status Report is filed, a payer is not able to certify that it has a functioning system for the electronic receipt and transmission of health care claim information in accordance with N.J.S.A. 17B:30-23, the payer shall file the required report together with supporting documents stating:

1. When compliance will be achieved; and

2. The reason(s) for the failure to comply.

(f) When those payers described in (e) above achieve compliance, a Final Operational Status Report shall be filed within seven days of achieving compliance.

(g) All reports described above in this section shall be filed at:

Department of Banking and Insurance
Attention: HINT/HIPAA Compliance
PO Box 325
20 West State Street
Trenton, NJ 08625-0325

11:22-3.5 Extensions of time and exemptions from compliance

(a) Health benefit payers may petition the Commissioner for an extension of the time limits set forth in N.J.A.C. 11:22-3.4 and/or to seek a waiver of the obligation to comply with the Act at any time after the filing of the First Operational Status Report filed in accordance with N.J.A.C. 11:22-3.4(b).

(b) Health benefit payers seeking an extension and/or exemption shall demonstrate that compliance with the timetable or these requirements will result in an undue hardship to the health benefit payer, a provider or a covered person.

(c) Small employer health benefit plans shall, upon application and approval by the Department, be granted an additional six months for compliance with the provisions of N.J.A.C. 11:22-3.4. To qualify, the group plan shall have less than 50 participants and/or less than $5 million in annual gross receipts.

11:22-3.6 Health care providers; claims

(a) On or after October 1, 2002, all payers shall require that all providers file all claims for payment unless the patient, at his or her option, files the claim directly.

(b) Where a claim is being filed by the health care provider on behalf of the patient without an assignment of benefits, the provider shall file the claim within 60 days of the last date of service of that course of treatment.

(c) Where the provider is filing a claim under an assignment of benefits from the patient, the provider shall file the claim within 180 days of the last date of service of the course of treatment.

(d) In the event a health care provider does not file the claim within 180 days of the last date of service of a course of treatment referred to in (c) above, the third party payer and/or

health benefit payer shall in accordance with N.J.A.C. 11:22-1.6 reserve the right to deny or dispute the claim and the health care provider shall be prohibited from seeking payment in whole or in part directly from the patient.

(e) When a health benefit payer takes action in accordance with (d) above, the health benefit payer shall advise the health care provider that payment of the claim, in whole or in part, will be made based upon consideration of the following factors that shall be addressed by the provider:

1. The good faith use of information provided by the patient to the health care provider with respect to the identity of the patient's health benefits payer;

2. Delays encountered in filing a claim related to the coordination of benefits among third party payers;

3. Whether the health care provider has previously filed untimely claims or has an established pattern of untimely claim practices;

4. Any prejudice to the rights of the patient and/or the health benefits provider in determination of the medical necessity of the services and care being billed for; and

5. Potential adverse impact to the public.

(f) Providers failing to file a claim within 180 days in accordance with (d) above whose claim for payment has been denied in whole or in part may, in the discretion of a Judge of the Superior Court, be permitted to refile the claim where there has not been substantial prejudice to the health benefit payer. Application to the Superior Court for permission to refile a claim shall be made within 14 days of the notification of denial of payment and shall be made upon motion based upon affidavit(s) showing sufficient reason(s) for the failure to file the claim with the third party payer within the required time.

11:22-3.7 Additional timetables

(a) On or before October 1, 2002, all payers shall file with the Department a plan for the sequential implementation of usage of the following standard transactions, code sets and forms described below:

1. 45 CFR 162.1201, Subpart L—Eligibility for a Health Plan;

2. 45 CFR 162.1301, Subpart M—Referral Certification and Authorization;

3. 45 CFR 162.1401, Subpart N—Health Care Claim Status;

4. 45 CFR 162.1601, Subpart P—Health Care Payment and Remittance Advice;

5. 45 CFR 162.1701, Subpart Q—Health Plan Premium Payments;

6. 45 CFR 162.1801, Subpart R—Coordination of Benefits; and

7. 277 Transactions, ANSI ASC X12.317, Version 003070, Release 7, Sub-release O, October 1996, Electronic Health Care Claim Status Notification.

(b) The plan referred to in (a) shall provide for full implementation of a system for the use of those electronic transaction and code sets referred to therein no later than October 16, 2002.

(c) In accordance with N.J.A.C. 11:22-1.3, payers receiving an electronically filed claim shall individually acknowledge receipt of each claim by responding with a 277 acknowledgement described in (a)7 above. Nothing in this section shall prevent payers from also using any other responses including, but not limited to, the 997 Functional Acknowledgement of batch transfers in addition to providing a 277 acknowledgement.

(d) In the event a provider's system is unable to receive a 277 acknowledgement, the payer shall establish a mutually agreeable alternative means of acknowledgement with the provider.

11:22-3.8 Use of clearinghouses in electronic transactions

(a) When computing the number of days for purposes of acknowledging an electronic claim and/or any other health care transactions required by this subchapter, the following shall apply:

1. When the provider chooses to use a clearinghouse for the transmission of claims to a payer, notice delivered by the payer to the clearinghouse shall constitute notice to the provider.

2. When a payer uses a clearinghouse for the receipt of any electronic transactions required by this subchapter, notice sent by the payer through the clearinghouse shall not constitute notice to a provider until it is delivered to the provider by the clearinghouse, or is available for pickup from the provider's mailbox at the clearinghouse.

3. When a payer and provider use the same clearinghouse for the transmission and receipt of health care transactions, notice that is sent by one party to the clearinghouse shall also constitute notice to the other party.

(b) In those instances where a payer elects to use the services of a clearinghouse (including a clearinghouse that is an affiliate of a payer) for the receipt, transmission, processing, storage and/or other handling of those electronic transactions required by this subchapter, a payer shall only use a clearinghouse that has been accredited by a national standards development organization that is properly authenticated and registered with the United States Attorney General and the Federal Trade Commission pursuant to the provisions

of the National Cooperation Research and Production Act of 1993, 15 USC §§4301 et seq.

(c) A national standards development organization that desires to accredit clearinghouses in the manner provided in this section may submit proof of its qualifications to do so as set forth in (b) above and a copy of its accreditation criteria or standards, which shall comply with the requirements set forth in (d) below.

(d) The accreditation of a clearinghouse by a national standards development organization shall measure the competency, assets, practices and procedures of the clearinghouse as to the following criteria:

1. Technical capacity and electronic facilities for the receipt, transmission and handling of electronic transactions;

2. Ability to process HIPAA complaint transactions;

3. Backup and disaster recovery plans and capacity;

4. Privacy practices, procedures and employee training programs consistent with HIPAA and the Health Information Electronic Data Interchange Technology Act, N.J.S.A. 17B:30-23 et seq. (HINT);

5. Security practices, procedures and employee training programs consistent with HIPAA and HINT; and

6. Compliance with the proper procedure for the existence and review of the business associate and trading partner agreements as defined in HIPAA.

(e) Payers shall not be required to comply with the provisions of (b) above until December 2, 2006.

Amended by R.2006 d.200, effective June 5, 2006.
See: 37 N.J.R. 4169(a), 38 N.J.R. 2501(a).
Inserted (b) through (e).

11:22-3.9 Information protection practices

All information and materials coming into the possession of health benefits payers, health care providers and their agents and vendors for the administration of the health care transactions described in this subchapter are subject to and shall comply with practices and requirements established in N.J.S.A. 17:23A-1 et seq., the Insurance Information Practices Act.

11:22-3.10 Fraud prevention and detection

(a) All payers shall deploy as part of any system for the electronic receipt and transmission of claims an anti-fraud program, resident system and/or software that is approved by the Department's Division of Anti-Fraud Compliance.

(b) The anti-fraud system described in (a) above shall be capable, at a minimum, of the following activities:

1. Screening all claims, pre-payment and/or post-payment, for data patterns associated with fraudulent activity;

2. Responding to audit specific inquiries to facilitate fraud investigations;

3. Identifying phantom vendors, employees, patients and providers;

4. Identifying inappropriate or inconsistent charges; and

5. Scanning provider claims for unnecessary and repetitive charges.

(c) The anti-fraud efforts described in this section shall be made a part of and incorporated into a payer's fraud prevention and detection plan when required pursuant to N.J.A.C. 11:16-6, as applicable.

(d) Those payers not required to have a fraud prevention and detection plan under N.J.A.C. 11:16-6 shall file a description of the system required by this section with:

New Jersey Department of Banking and Insurance
Division of Anti-Fraud Compliance
Attn: HINT/HIPAA-Fraud Prevention and
Detection Plans
PO Box 324
20 West State Street
Trenton, NJ 08625-0324

(e) Payers shall comply with the requirements of N.J.S.A. 17:33A-1 et. seq. regarding the obligation to report suspected fraud to the New Jersey Office of Insurance Fraud Prosecutor.

11:22-3.11 Penalties

Failure to comply with this subchapter may result in the imposition of penalties as authorized by law, including suspension or revocation of the payer's authority to do business in the State of New Jersey.

APPENDIX

Exhibit 1

(RESERVED)

Repealed by R.2004 d.460, effective December 20, 2004.
See: 36 N.J.R. 1282(a), 36 N.J.R. 5913(a).

[Carrier Logo][1]
[Carrier Name][2]

Enrollment/Change Request

[Employer][3] Group Information – To be completed by [Employer]

Group Name _____ [Group Number _____ Class Code][4] _____

A. Type of Activity – To Be Completed by [Employer]. Refer to instructions [on back][5] before completing this form. Print clearly.

1. Enrollment [ ] New [Enrollee/Subscriber][6] Effective Date ___/___/___ Date of Hire ___/___/___

2. Change – Check all that apply

	Date of Event	Reason
[ ] Add Spouse	___/___/___	_____
[ ] Add Domestic Partner	___/___/___	_____
[ ] Add Dependent Child	___/___/___	_____
[ ] Name Change	___/___/___	_____
[ ] Change Plan	___/___/___	_____
[ ] Other	___/___/___	_____

[ ] [Add/Change Office ID Numbers: Primary / Ob/Gyn / Dentist][7]

3. Remove or Terminate – Check all that apply

	Effective Date	Reason
[ ] Remove Spouse*	___/___/___	_____
[ ] Remove Domestic Partner*	___/___/___	_____
[ ] Remove Dependent Child*	___/___/___	_____
[ ] [Employee] Withdrawal/Termination	___/___/___	_____

NOTE: [Employee] must be enrolled for spouse/dependent(s) to have coverage.

*Please complete *Add/Change/Remove* and *Name* columns in Section D.

4. Continuation of Coverage, i.e. COBRA, State, total disability. Not all options are available or applicable. Contact [Employer] for available options.
   Coverage for: [ ] [Employee] [ ] Dependents
   Length of Continuation: [ ] 12 mos [ ] 18 mos [ ] 29 mos [ ] 36 mos [ ] total disability*
   Date of Loss of Coverage: ___/___/___ Date of Qualifying Event: ___/___/___
   [Billing: [ ]Home [ ] Group][8]

*Attach proof of total disability

B. [Employee] Information – Complete Sections [B-H][9]

Last name, First name, M.I. _____
Social Security Number _____ Home Telephone _____ [E-mail Address _____]
Home address _____ Apt. No. _____ City, State_____ Zip Code _____
[Employer] Name _____ Work Telephone _____
Work address _____ City, State_____ Zip Code _____
Date of Employment: _____ Hours worked per week:

C. **Plan Option** – Your selection must be offered by [your Employer]
Check one: [Indicate Plan Names/Copays/Deductibles/Coverage Status][10]

D. **Individuals Covered** – List individuals for whom you are adding/changing/removing coverage. Attach sheet to list additional children. [Attach proof if full-time post-secondary student. Attach proof of disability][11]

	(A)dd (C)hange (R)emove	Last Name, First Name, MI	Sex M F	Birthdate MM DD YYYY	Social Security Number	Other Health Coverage	[Other Rx Drug Coverage][14]	[Primary Office ID Number][12]	[Current Patient][13]	[Ob/Gyn Office ID Number] (if applicable)[15]	[Current Patient]	[Dentist Office ID Number] (if applicable)[16]	[Current Patient]	Previous Coverage Check if yes
[Employee]				/ /										
Domestic Partner				/ /										
Spouse				/ /										
Child				/ /										
Child				/ /										
Child				/ /										
Child				/ /										
Child				/ /										

[E. Pre-Existing Conditions Statement][17]

[Note: This information may ONLY be used to determine if a condition is a pre-existing condition. You CANNOT be denied coverage under a health benefits plan on the basis of accurate responses to the following questions. Carriers can only use the information to expedite the processing of claims.

Yes No 1. During the past [6][18] months, have you or any dependent to be covered had or been diagnosed as having any of the following? If "Yes," check appropriate box(es) below.

[ ] [ ]
- [ ] a. Alcoholism or Drug Abuse
- [ ] b. Arthritis
- [ ] c. Blood Disorder
- [ ] d. Back or Neck Disorder, Injury or Pain
- [ ] e. Cancer or Tumors
- [ ] f. Diabetes
- [ ] g. Gastro or Intestinal Disorder
- [ ] h. Heart Disorder or Condition or Chest Pain
- [ ] i. High Blood Pressure
- [ ] j. Kidney or Liver Disorder
- [ ] k. Lung or Respiratory Disorder
- [ ] l. Mental or Nervous Disorder
- [ ] m. Paralysis, Stroke or Epilepsy

Yes No 2. During the past [6] months, have you or any dependent to be covered:

- [ ] [ ] a. been examined or treated by a physician or other health care provider for any condition, illness, or injury, other than as stated above?
- [ ] [ ] b. been advised to have treatment or surgery or testing that has not been done?
- [ ] [ ] c. been admitted to a hospital or other health care facility as an inpatient?
- [ ] [ ] d. taken prescribed medication?

Please give details for "Yes" answers to any part of Questions 1 or 2 on a separate sheet of paper. This separate sheet should be signed and dated.]

[F]. Other / Previous Insurance

Is your spouse employed? [ ] Yes [ ] No If "Yes" give name and address of your spouse's employer

_____

If "Yes" to Other Health Coverage (Section D), give names & policy numbers of insurance carrier, HMO, or other source. If enrolled in Medicare Parts A and/or B identify the coverage and provide the Medicare ID #.

If "Yes" to Other Rx Drug Coverage (Section D), give name & policy number of insurance carrier, HMO, or other source.

If "Yes" to Previous Coverage, identify name(s) of persons, give effective date and date coverage terminated, name of previous carrier and plan number [, and submit a copy of the Certificate of Creditable Coverage that was issued by the previous carrier, if available.][19]

[G]. Dependent Information

Does any dependent listed in Section D live at a different address than the [Employee]? [ ] Yes [ ] No If "Yes" who and at what address?

Explain the circumstances.

If any dependent's last name differs from yours, explain the circumstances.

[H] Race/Ethnicity (*RESPONDING TO THIS QUESTION IS OPTIONAL AND NOT REQUIRED)

Choose a category that most closely describes you:

[ ] a. American Indian or Alaskan Native
[ ] b. Asian or Pacific Islander
[ ] c. Black, not of Hispanic origin
[ ] d. Hispanic
[ ] e. White, not of Hispanic origin

[I] [Employee] Signature *If you have questions concerning the benefits and services provided by or excluded under this [Agreement][20] contact a [Member Services][21] representative at [phone number][22] before signing this form.*

I represent that all the information supplied in this application is true and complete. I hereby agree to the conditions of enrollment on the [reverse] side of the [employee] copy of this enrollment/change request. I authorize deductions from my earnings for any required contributions.

[Employee] Signature – Required X _____ Date ___/___/___ E-Mail Address_____

[J] [Employer] Verification – To be Completed by [Employer]

[Employer] Signature – Required X _____ Title _____ Date ___/___/___

[[Employee] copy may be used as a temporary ID card for 30 days from the effective date if authorized by [employer]. Coverage must be verified with [Carrier name] prior to visiting a specialist or admission to a hospital.][23]

[NJ-HINT]
[Internal Carrier Form Number][24]

Instructions

[Employer]

- Complete the [Employer] Group information [in the upper right corner] of the form.
- Section A – Type of Activity: Check boxes indicating reason(s) for submitting application.
- Complete Section [J] – [Employer] Verification [in the lower right corner] of the form.
  - [Employer] must complete this section for all new enrollments, coverage changes and terminations.
  - [Employer] must sign and date the Enrollment/Change Request in order for it to be processed.

[Employee] – Complete Sections [B-H]

Section B – [Employee] Information:

- Complete all information in order for your application to be processed.

Section C – Plan Option:

- [Check one Plan Option box, indicate Plan Option Name (where applicable) and check one Copay and/or Individual Deductible Amount (if applicable).]
- Select only an option offered by your [employer].

Section D – Individuals Covered:

- Add/Change/Remove – Use "A", "C", or "R" to indicate whether you are adding, changing or removing coverage for an individual.
- Print your full name along with the name(s) of your dependents, if applicable. Indicate Sex, Birthdate, and Social Security Number for each individual listed.
- [If a dependent is a full-time post-secondary student, you must attach a current course schedule or a letter from the school or its authorized representative confirming full-time student status. If dependent is disabled and being continued beyond the limiting age, attach proof of disability]
- If you or your dependent(s) have other Health [or Rx drug] coverage, check off the "Yes" box(es) and complete Section [F] — Other/Previous Insurance.
- [From the appropriate provider directory, locate the [6-digit] office ID number for the primary care physician, ob/gyn (if applicable), and/or dentist (if applicable). Indicate office ID number selection(s) on the form.]
- [If you are a current patient, please check the "Current Patient" box.]

Section [E] – Pre-Existing Conditions Statement:

- Complete this section for all new enrollments. Exceptions: For Small Employer Group coverage, this section must be completed only by persons enrolling in group coverage in a group of 2–5 [employees] and by late entrants.]

Section [F] Other / Previous Insurance

- Complete this section for all new enrollments or coverage changes. Coverage includes group coverage. governmental coverage, a church plan or Medicare.

Section [G] – Dependent Information

- Complete this section for all new enrollments or coverage changes

Section [H] – Race/Ethnicity

- Responding to this question is optional and NOT required.
- Complete this section for all new enrollments.

Section [I] – [Employee] Signature:

- Complete this section for all new enrollments, coverage changes and terminations.
- [Employee] must sign and date the Enrollment/Change Request Form in order for it to be processed.

Section [J] – [Employer] Verification:

- [Employer] must complete this section for all new enrollments, coverage changes and terminations.
- [Employer] must sign and date the Enrollment/Change Request Form in order for it to be processed.

Conditions of Enrollment

[Applicant] Acknowledgement and Agreements

On behalf of myself and the dependents listed [on the reverse side] I agree to or with the following:

1. a) I authorize the sources stated below to give to [Carrier Name], or any consumer reporting agency acting on its behalf, information about me and my minor children, if applying for coverage. Such information will pertain to employment, other health coverage, and medical advice, treatment or supplies for any physical or mental condition, Authorized sources are any physician or medical professional; any hospital, clinic or other medical care institution; any carrier; any consumer reporting agency; any employer.

   b) I understand that I may revoke this authorization at any time. I agree that such revocation will not affect any action which [carrier] has taken in reliance on the authorization. I understand this authorization will not be valid after 30 months, if not revoked earlier.

   c) I know that I have a right to receive a copy of the authorization if I request one.

   d) I agree that a photocopy of this authorization is as valid as the original.
2. I acknowledge by enrolling in a [Carrier Name] [plan or group policy] coverage is provided by [Carrier Name] in accordance with the contract.
3. Enrollment of myself and of the listed dependents into the plan is effective on acceptance by [Carrier Name].
4. Coverage and benefits are contingent on timely payment of premiums and may be terminated as provided in the plan documents. My employer is hereby authorized to withhold payments from my wages, as appropriate.

Misrepresentation

5. Any person who includes any false or misleading information on an Enrollment/Change Request Form for a health benefits plan is subject to criminal and civil penalties.

---

[1] Replace bracketed text with carrier's logo, or omit.

[2] Replace bracketed text "carrier name" with carrier's full name throughout the document.

[3] If the carrier refers to the "Employer" using another term such as "Planholder" or "Contractholder" or some similar term, replace the term "Employer" with such other term throughout the document.

[4] If the carrier refers to "Group Number/Class Code" using some other term such as "Policy Number," "Control Number" or some similar term, replace the term "Group Number/Class Code" with such other term.

[5] Replace "on back" with appropriate directions if the instructions are not provided on the reverse side. "Add Domestic Partner" if coverage offered.

[6] If the carrier refers to the "Enrollee/Subscriber" using another term such as "Member" or "Applicant" or some similar term, replace the term "Enrollee/Subscriber" with such other term throughout the document.

[7] Omit one or more "Add/Change Office ID Numbers" options if carrier does not offer such options.

[8] The continuation billing options should be omitted if the carrier does not offer such options.

[9] Re-letter Sections F – H accordingly if Section E Pre-Existing Conditions Statement is being omitted. Add e-mail address if option offered.

[10] Insert carrier plan options and deductibles, coinsurance or copayment options.

[11] If the carrier does not want the proof of full-time student status provided with the enrollment form and/or proof of disability, omit the directions to attach proof.

[12] Omit "Primary Office ID Number" section if the plan does not require the selection of a Primary Care Physician.

[13] Omit "Current Patient" section if the carrier does not require.

[14] Omit "Rx Drug" section and corresponding question in Section F if carrier does not require.

[15] Omit "Ob/Gyn Office ID Number" section if the plan does not require the selection of an Ob/Gyn Physician.

[16] Omit "Dentist Office ID Number" section if the plan does not require the selection of a Dentist.

[17] The text "and pre-existing conditions statement" should be omitted if the carrier does not elect to include the pre-existing conditions statement text as part of the standard enrollment form. Re-letter succeeding sections.

[18] Carrier's pre-existing conditions period. For plans other than small employer plans, insert the pre-existing conditions periods that are contained in non-small employer plans. For small employer plans, the period is six months.

[19] If the carrier does not want the Certificate of Creditable Coverage to be supplied with the Enrollment/Change Request, omit the directions to supply it.

[20] If the carrier refers to the "Agreement" using another term such as "Plan," "Contract", "Policy" or some similar term, replace the term "Agreement" with such other term throughout the document.

[21] If the carrier refers to the "Member Services" using another term such as "Claim Office" or "Customer Service" or some similar term, replace the term "Member Services" with such other term.

[22] Insert carrier's phone number.

[23] Carrier should insert the procedure to be followed to allow the applicant to secure coverage before the actual ID card is issued.

[24] Available for carriers that use an internal number in addition to the identifying form number.

NJ-HINT-Group [Internal Carrier Form Number]

New Rule, R.2004 d.460, effective December 20, 2004.
See: 36 N.J.R. 1282(a), 36 N.J.R. 5913(A).
Administrative correction.
See: 37 N.J.R. 530(b).

Amended by R.2005 d.365, effective November 7, 2005.
See: 37 N.J.R. 2291(a), 37 N.J.R. 4272(a).
Added new section [H]; recodified existing sections [H] and [I] as [I] and [J].

[Carrier Logo][1] **Application/Change Request**
[ ] [Carrier Name][2]

A. Type of Activity – Refer to instructions [on back][3] before completing this form. Print clearly.

1. Enrollment [ ] New [Enrollee/Subscriber][4] Requested Effective Date ___/___/___

2. Change – Check all that apply

	Date of Event	Reason
[ ] Add Spouse	___/___/___	_____
[ ] Add Domestic Partner	___/___/___	_____
[ ] Add Dependent Child	___/___/___	_____
[ ] Name Change	___/___/___	_____
[ ] Change Plan	___/___/___	_____
[ ] Other	___/___/___	_____

[ ] [Add/Change Office ID Numbers: Primary / Ob/Gyn][5]

3. Remove or Terminate – Check all that apply

	Effective Date	Reason
[ ] Remove Applicant*	___/___/___	_____
[ ] Remove Spouse*	___/___/___	_____
[ ] Remove Domestic Partner	___/___/___	_____
[ ] Remove Dependent Child	___/___/___	_____

*Please complete *Add/Change/Remove* and *Name* columns in Section D.

B. [Applicant] Information – Complete Sections [B-H][6]

Last name, First name, M.I. _____ E-mail Address _____
Social Security Number _____ Home Telephone _____ Work Telephone _____
Home address _____ Apt. No. ____ City, State _____ Zip Code _____
Primary Residence _____ Apt. No. ____ City, State _____ Zip Code _____
Are you a resident of the State of New Jersey? [ ] Yes [ ] No
Do you maintain a residence in any other state? [ ] Yes [ ] No
If "Yes" name of state _____ How much time do you spend there each year? _____

C. Plan Option - Check one.
[Indicate Plan Names/Copays/Deductibles/Coinsurance/Coverage Status][7]

NJ-HINT-Individual [Internal Carrier Form Number]

D. Individuals Covered – List Individuals for whom you are adding/changing/removing coverage. Attach sheet to list additional children. [Attach proof if full-time post-secondary student. Attach proof of disability][8]

	[A]dd (C)hange (R)emove	Last Name, First Name, MI	Sex M F	Birthdate MM DD YYYY	Social Security Number	[Primary Office ID Number][9]	[Current Patient][10]	[Ob/Gyn Office ID Number (if applicable)][11]	[Current Patient]]	Previous Coverage Check if yes
[Applicant]				/ /						
Spouse				/ /						
Domestic Partner				/ /						
Child				/ /						
Child				/ /						
Child				/ /						
Child				/ /						
Child				/ /						

[E. Pre-Existing Conditions Statement][12]

[Note: This information may ONLY be used to determine if a condition is a pre-existing condition. You CANNOT be denied coverage under a health benefits plan on the basis of accurate responses to the following questions. Carriers can only use the information to expedite the processing of claims.

Yes [ ] No [ ] 1. During the past 6 months, have you or any dependent to be covered had or been diagnosed as having any of the following? If "Yes," check appropriate box(es) below.

- [ ] a. Alcoholism or Drug Abuse
- [ ] b. Arthritis
- [ ] c. Blood Disorder
- [ ] d. Back or Neck Disorder, Injury or Pain
- [ ] e. Cancer or Tumors
- [ ] f. Diabetes
- [ ] g. Gastro or Intestinal Disorder
- [ ] h. Heart Disorder or Condition or Chest Pain
- [ ] i. High Blood Pressure
- [ ] j. Kidney or Liver Disorder
- [ ] k. Lung or Respiratory Disorder
- [ ] l. Mental or Nervous Disorder
- [ ] m. Paralysis, Stroke or Epilepsy
- [ ] n. Does pregnancy exist?

Expected Due Date _____

Yes [ ] No [ ] 2. During the past 6 months, have you or any dependent to be covered:

- [ ] a. been examined or treated by a physician or other health care provider for any condition, illness, or injury, other than as stated above?
- [ ] b. been advised to have treatment or surgery or testing that has not been done?
- [ ] c. been admitted to a hospital or other health care facility as an inpatient?
- [ ] d. taken prescribed medication?

Please give details for "Yes" answers to any part of Questions 1 or 2 on a separate sheet of paper. This separate sheet should be signed and dated.]

[F]. Previous Insurance

If yes to previous coverage provide the following

Name	Individual or Group Other (specify)	Plan Type Indemnity/PPO POS/HMO	Deductible	Coinsurance	Copay	Effective Date	Termination Date	Carrier Name	Policy Name

NJ-HINT-Individual [Internal Carrier Form Number]

[G]. Dependent Information

Does any dependent listed in Section D live at a different address than the [Applicant]? [ ] Yes [ ] No If "Yes" identify the individual(s) and at what address?

Explain the circumstances.

If any dependent's last name differs from yours, explain the circumstances.

[H] Availability of Coverage

Are you or any person named on this application eligible for coverage under a group or governmental plan, a church plan, Medicare, Medicaid or any successor program? [ ] Yes [ ] No
If "Yes" identify the individual(s), give name of carrier, policy number and identify coverage type.

Are you or any person named on this application covered under a group or governmental plan, a church plan or Medicare? [ ] Yes [ ] No
If "Yes" identify the individual(s), give name of carrier, policy number and identify coverage type.

Was previous coverage, if any, terminated because a person covered under the plan committed fraud or for failure to pay premiums? [ ] Yes [ ] No
If "Yes" identify the individual(s), and briefly describe the circumstances.

Were any of the individuals to be covered under an individual plan given the opportunity to continue previous coverage, if any, under COBRA or a similar state continuation law? [ ] Yes [ ] No
If "Yes" did the individual(s) remain covered far the entire period that continuation was available to him or her? [ ] Yes [ ] No
Identify any person who did not continue for entire period available.

Were any of the individuals to be covered under an individual plan, as of the date of this application, continuously covered under a previous plan or plans for a period of 18 or more months without a break in coverage of 63 or more days? [ ] Yes [ ] No
If "Yes" identify the individual(s)

Were any of the individuals' most recent prior creditable coverage under a group health plan, governmental plan, church plan, or health insurance coverage offered in connection with any such plan? [ ] Yes [ ] No
If "Yes" identify the individual(s)

[Please include a Certificate of Creditable Coverage, if available.][13]

NJ-HINT-Individual [Internal Carrier Form Number]

[I] Race/Ethnicity (*RESPONDING TO THIS QUESTION IS OPTIONAL AND NOT REQUIRED)

Choose a category that most closely describes you:

[ ] a. American Indian or Alaskan Native

[ ] b. Asian or Pacific Islander

[ ] c. Black, not of Hispanic origin

[ ] d. Hispanic

[ ] e. White, not of Hispanic origin

[J] Payment Information

[ ] Monthly [[ ] Quarterly] [[ ] Semi-Annually]

Payment Instrument: [ ] Check [ ] Money Order [[ ] Credit Card Type/Name on Credit Card _____ No. _____ Exp. Date _____

Name on Card _____] [[ ] Automatic Bank Draft (attach voided check)][14]

[K] [Applicant] Signature *If you have questions concerning the benefits and services provided by or excluded under this [Policy][15] contact a [Member Services][16] representative at [phone number][17] before signing this form.*

I represent that all the information supplied in this application is true and complete. I hereby agree to the conditions of enrollment on the [reverse] side of the [applicant] copy of this application/change request.

[Applicant] Signature – Required X _____ Date ___/___/___ E-Mail Address _____

[[Applicant] copy may be used as a temporary ID card for 30 days from the effective date if authorized by [carrier]. Coverage must be verified with [Carrier name] prior to visiting a specialist or admission to a hospital.][18]

[L]. Broker/General Agent Information

Signature of Preparer: _____ Date ___/___/___ NJ Producer License #:_____

General Agent: _____ Agent ID #: _____[19]

[Internal Carrier Form Number][20]

Eligibility Requirements

1. Eligibility requirements are determined under the Individual Health Coverage Reform Act of 1992, P.L. 1992, c. 161.
2. You must be a New Jersey resident.
3. You and any family members you wish to cover must not be eligible to be covered under:
   (a) A group Health Benefits Plan, Group Health Plan, Governmental Plan, or Church Plan; or
   (b) Medicare (See Eligibility Requirements item 5 below.)
4. You and any family members you wish to cover are not eligible for a standard individual health benefits plan if covered by another individual health benefits plan unless the other plan is being replaced by the plan being applied for with this application.
5. If the requested effective date is not completed, your effective date shall be no later than the first of the month following the month in which the completed application was dated and premium payment are received by us or our duly authorized agent. However, with respect to applications submitted during the October Open Enrollment Period by persons who are eligible for coverage under a group Health Benefits Plan, Group Health Plan, Governmental Plan, or Church Plan, or persons who wish to replace their current health benefit plan with a more comprehensive individual health benefits plan, the effective date of coverage shall be January 1 of the following calendar year. Current coverage should not be terminated until new coverage is in effect.

Instructions

Section A – Type of Activity
Provide all information that applies to the reason you are completing this application/change form.
Section B – [Applicant] Information:
Complete all information in order for your application to be processed.
Section C – Plan Option:
[Check one Plan Option box, indicate Plan Option Name (where applicable) and check one Copay and/or Individual Deductible Amount (if applicable).]
Section D – Individuals Covered:

- Add/Change/Remove – Use "A", "C", or "R" to indicate whether you are adding, changing or removing coverage for an individual.
- Print your full name along with the name(s) of your dependents, if applicable. Indicate Sex, Birthdate, and Social Security Number for each individual listed.
- [If a dependent is a full-time post-secondary student, you must attach a current course schedule or a letter from the school or its authorized representative confirming full-time student status. If dependent is disabled and being continued beyond the limiting age, attach proof of disability]
- [From the appropriate provider directory, locate the [6-digit] office ID number for the primary care physician, ob/gyn (if applicable). Indicate office ID number selection(s) on the form.]
- [If you are a current patient, please check the "Current Patient" box.]

Section [E] – PreExisting Conditions Statement:
Complete this section for all new enrollments
Section [F] – Previous Insurance
Complete this section for all new enrollments or coverage changes. Coverage includes individual or group coverage, governmental coverage, a church plan, or Medicare or Medicaid (including NJ FamilyCare).
Section [G] – Dependent Information
Complete this section for all new enrollments or coverage changes
Section [H] – Race/Ethnicity

- Responding to this question is optional and NOT required.
- Complete this section for all new enrollments.

Section [K] – [Applicant] Signature:

- Complete this section for all new enrollments, coverage changes and terminations.
- [Applicant] must sign and date the Application/Change Request Form in order for it to be processed.

NJ-HINT-Individual [Internal Carrier Form Number]

Conditions of Enrollment

[Applicant] Acknowledgement and Agreements

On behalf of myself and the dependents listed [on the reverse side], I agree to or with the following:

1. a) I authorize the sources stated below to give to [Carrier Name], or any consumer reporting agency acting on its behalf, information about me and my minor children, if applying for coverage. Such information will pertain to employment, other health coverage, and medical advice, treatment or supplies for any physical or mental condition. Authorized sources are any physician or medical professional; any hospital, clinic or other medical care institution; any carrier; any consumer reporting agency; any employer.
   b) I understand that I may revoke this authorization at any time. I agree that such revocation will not affect any action which [Carrier Name] has taken in reliance on the authorization. I understand this authorization will not be valid after 30 months, if not revoked earlier.
   c) I know that I have a right to receive a copy of the authorization if I request one.
   d) I agree that a photocopy of this authorization is as valid as the original.
2. I acknowledge by enrolling in a [Carrier Name] individual [policy] coverage is provided by [Carrier Name] in accordance with the contract.
3. Enrollment of myself and of the listed dependents into the plan is effective on acceptance by [Carrier Name].
4. Coverage and benefits are contingent on timely payment of premiums and may be terminated as provided in the [policy].

Misrepresentation

5. Any person who includes any false or misleading information on an Application/Change Request Form for a health benefits plan is subject to criminal and civil penalties.

---

[1] Replace bracketed text with carrier's logo, or omit.
[2] Replace bracketed text "carrier name" with carrier's full name throughout the document.
[3] Replace "on back" with appropriate directions if the instructions are not provided on the reverse side.
[4] If the carrier refers to the "Enrollee/Subscriber" using another term such as "Member" or "Applicant" or some similar term, replace the term "Enrollee/Subscriber" with such other term throughout the document. Add "Domestic Partner" if coverage offered.
[5] Omit one or more "Add/Change Office ID Numbers" options if carrier does not offer such options.
[6] Re-letter Sections F.– H accordingly if Section E Pre Existing Conditions Statement is being omitted. Add e-mail address if option offered.
[7] Insert carrier plan options and deductibles, coinsurance or copayment options. The listed options must be consistent with the requirements of N.J.A.C. 11:20-3.
[8] If the carrier does not want the proof of full-time student status provided with the enrollment form and/or proof of disability, omit the directions to attach proof.
[9] Omit "Primary Office ID Number" section if the plan does not require the selection of a Primary Care Physician.
[10] Omit "Current Patient" section if the carrier does not require.
[11] Omit "Ob/Gyn Office ID Number" section if the plan does not require the selection of an Ob/Gyn Physician.
[12] The text "and pre-existing conditions statement" should be omitted if the carrier does not elect to include the pre-existing conditions statement text as part of the standard application form. Re-letter succeeding sections.
[13] If the carrier does not want the Certificate of Credible Coverage to be supplied with the Application/Change Request, omit the directions to supply it.
[14] Omit those payment options or modes that are unavailable.
[15] If the carrier refers to the "Policy" using another term such as "Plan," "Contract," or some similar term, replace the term "Policy" with such other term throughout the document.
[16] If the carrier refers to the "Member Services" using another term such as "Claim Office" or "Customer Service" or some similar term, replace the term "Member Services" with such other term.
[17] Insert carrier's phone number.
[18] Carrier should insert the procedure to be followed to allow the applicant to secure coverage before the actual ID card is issued.
[19] Omit if the carrier does not use agents in the sale of individual plans. The text of this Broker/General Agent section may be modified to include the specific broker/general agent information the carrier requires. The scope of the information included in this section is limited to information concerning the broker/general agent or agent.
[20] Available for carriers that use an internal number in addition to the identifying form number.

New Rule, R.2004 d.460, effective December 20, 2004.
See: 36 N.J.R. 1282(a), 36 N.J.R. 5913(a).
Amended by R.2005 d.365, effective November 7, 2005.
See: 37 N.J.R. 2291(a), 37 N.J.R. 4272(a).
Added new section [I]; recodified existing [I]-[K] as [J]-[L].

EXHIBIT 2

New Jersey Department of Banking and Insurance
ATTN: HINT Status Reports
20 West State Street
PO Box 325
Trenton, NJ 08625-0325

HINT Operational Status Report

1. This is the
   (Indicate one):
   [ ] First Report due on _____
   [ ] Interim Report due on _____
   [ ] Final Report due on _____
2. The current status of the implementation of HINT electronic filing reports for health care benefit payment systems is:
   _____
   _____
   _____
   _____
   _____
3. If compliance is not yet achieved, indicate when the requirements of N.J.A.C. 11:22-3 will be accomplished:
   _____
   _____
   _____
   _____
   _____
4. What specific obstacles have been identified that may cause the filer NOT to comply with the timetable set forth in N.J.A.C. 11:22?
   _____
   _____
   _____
   _____
   _____
5. Is the filer requesting an extension of time to comply with the timetable now or in the future?
   ____ No ____ Yes
   If yes, why: _____
   _____
   _____
   _____
   _____
6. Is the filer requesting a waiver from compliance with the HINT Electronic System request now or in the future?
   ____ No ____ Yes
   If yes, why: _____
   _____
   _____
   _____
   _____
7. Will the filer comply with the timetable for implementation of the additional transaction identified in N.J.A.C. 11:22-3.7?
   _____
   _____
   _____
   _____
8. Other issues:
   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____

_____ hereby certifies that the foregoing statements of fact are true and understand that he/she is subject to punishment for any intentional misstatements of fact.

_____ _____
Date Name

_____
Agency

_____
Title of Signatory

New Rule, R.2001 d.364, effective October 1, 2001.
See: 33 N.J.R. 750(a), 33 N.J.R. 3461(a).
Administrative correction.
See: 39 N.J.R. 1739(a).

APPENDIX
EXHIBIT 3

Dental Claim Form

1. ☐ Dentist's pre-treatment estimate ☐ Dentist's statement of actual services Specialty (see backside)	3. Carrier Name
2. ☐ Medicaid Claim ☐ EPSDT Prior Authorization #	4. Carrier Address
	5. City / 6. State / 7. Zip

PATIENT

8. Patient Name (Last, First, Middle)	9. Address	10. City		11. State
12. Date of Birth (MM/DD/YYYY) / /	13. Patient ID #	14. Sex ☐M ☐F	15. Phone Number ( )	16. Zip Code
17. Relationship to Subscriber/Employee: ☐Self ☐Spouse ☐Child ☐Other_____			18. Employer/School Name_____ Address_____	

SUBSCRIBER / EMPLOYEE

19. Subs./Emp. ID#/SSN#	20. Employer Name	21. Group #		
22. Subscriber/Employee Name (Last, First, Middle)				
23. Address		24. Phone Number ( )		
25. City	26. State	27. Zip Code		
28. Date of Birth (MM/DD/YYYY) / /	29. Marital Status ☐Married ☐Single ☐Other	30. Sex ☐M ☐F		

39. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim.

X_____
Signed (Patient/Guardian) Date (MM/DD/YYYY)

OTHER POLICIES

31. Is Patient covered by another plan ☐No (Skip 32–37) ☐Yes: ☐Dental or ☐ Medical		32. Policy #
33. Other Subscriber's Name		
34. Date of Birth (MM/DD/YYYY) / /	35. Sex ☐M ☐F	36. Plan/Program Name
37. Employer/School Name_____ Address_____		
38. Subscriber/Employee Status ☐Employed ☐Part-time Status ☐Full-time Student ☐Part-time Student		
40. Employer/School Name_____ Address_____		

41. I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.

X_____
Signed (Employee/subscriber) Date (MM/DD/YYYY)

BILLING DENTIST

42. Name of Billing Dentist or Dental Entity			43. Phone Number ( )	44. Provider ID # / 45. Dentist Soc. Sec. or T.I.N.
46. Address			47. Dentist License #	48. First visit date of current series: / 49. Place of treatment ☐Office ☐Hosp. ☐ECF ☐Other
50. City	51. State	52. Zip Code	53. Radiographs or models enclosed? ☐Yes, How many?_____ ☐No	54. Is treatment for orthodontics? ☐Yes ☐No If service already commenced:
55. If prosthesis (crown, bridge, dentures), is this initial placement? ☐Yes ☐No			If no, reason for replacement: _____ Date of prior placement: _____	Date appliances placed _____ Total mos. of treatment remaining _____
56. Is treatment result of occupational illness or injury? ☐No ☐ Yes Brief description and dates_____			57. Is treatment result of: ☐auto accident? ☐other accident? ☐neither Brief description and dates_____	

58. Diagnosis Code Index (optional)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____ 8. _____

59. Examination and treatment plans – List teeth in order

Date (MM/DD/YYYY)	Tooth	Surface	Diagnosis Index #	Procedure Code	Qty	Description	Fee	Admin. Use Only

60. Identify all missing teeth with "X"

Permanent																Primary																Total Fee	
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J							Payment by other plan	
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K							Max. Allowable	

61. Remarks for unusual services

Deductible
Carrier %
Carrier pays
Patient pays

62. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

X_____
Signed (Treating Dentist) License # Date (MM/DD/YYYY)

63. Address where treatment was performed

64. City / 65. State / 66. Zip Code

The following is an itemized description of the questions appearing on the new form. Thoroughly complete the Billing Dentist Section to facilitate prompt and accurate reimbursement and to reduce follow-up inquiries.

1. Dentist's pretreatment estimate **or** statement of actual services and identification of specialty: Complete appropriate box to expedite processing and decrease chance of error. Indicate dentist's specialty by using the following abbreviations: END (Endodontist); OPY (Oral Pathologist); ORT (Orthodontist); OSY (Oral Surgeon); PDT (Periodontist); PED (Pedodontist); PHD (Public Health Dentist) and PST (Prosthodontist).
2. Medicaid Claim, EPSDT, prior authorization number: Check for government-funded benefit programs.

3-7. Carrier name, address, city, state, zip code: Carrier information where the claim is to be sent.

8-11, 16. Patient name address, city, state, and zip code: Include the patient's legal name.

12. Patient date of birth: Necessary to determine eligibility.
13. Patient ID number: Used by dental office to identify patient. Not required to process claim.
14. Sex: Necessary for identification purposes and for statistical analysis.
15. Patient phone number: Necessary if questions arise that require immediate attention.
17. Relationship to subscriber/employee: Relationship between the insured person and the patient may affect the patient's eligibility, as well as level of benefits available.
18. Employer/School name and address: Eligibility of the dependent patient may be affected if the patient is over a certain age and is still a full-time student. This information may be necessary for coordination of benefits (COB).
19. Subscriber/Employee ID # or Social Security number: This information refers to the insured person and is not necessarily the patient. The Social Security number (SSN) is commonly used for computer and manual processing of claims.
20. Employer name: Self explanatory.
21. Group number: Refers to the master contract policy number assigned to the employer group.

22-30. Subscriber/Employee information: Refers to the insured person; and is not necessarily the patient.

31. Is patient covered by another dental plan: Necessary to determine multiple coverage and COB.
32. Policy #: Refers to master contract policy number assigned to the employer group.

33-35. Other subscriber's information: Refers to employee with policy number in box #32.

36. Plan/Program name: Necessary to identify national programs such as TRICARE.
37. Employer/School: Refers to person in box #33. Necessary for eligibility requirements and COB.
38. Subscriber/Employer status: Refers to person in box #22. May be necessary for eligibility and COB.
39. Patient signature block: The patient is defined as an individual who has established a professional relationship with a dentist for the delivery of dental health care. For matters relating to communication of information and consent, this term includes the patient's parent, caretaker, guardian, or other individual as appropriate under state law and the circumstances of the case.
40. Employer/School: Refers to person in box #22. May be necessary for COB. Not required by all carriers.
41. Employee/subscriber block: Necessary when the patient and/or the dentist wish to have benefits paid directly to the provider. This is an authorization of payment and does not constitute an assignment of benefits. It does not create a contractual relationship between the dentist and the payer.

42-43,46,50-52. Information for Billing Dentist, or Dental Entity: The individual dentist's name or the name of the group practice/corporation responsible for billing and other pertinent information. This may differ from the actual treating dentist's name. This is the information that should appear on any payments or correspondence that will be remitted to the billing dentist.

44. Provider ID #: Necessary when carriers assign unique numbers to providers that differ from the Social Security number or the tax payer identification number (T.I.N).
45. Dentist's Social Security number or T.I.N.: Refers to dentist or dental entity in box #42. The Internal Revenue Service requires that either the Social Security or T.I.N. of the billing dentist or dental entity be supplied only if the provider accepts payment directly from a third-party payer. Report the SS# if the billing dentist is unincorporated. Report the corporation T.I.N. if the billing dentist is incorporated or the entity T.I.N. when the billing entity is a group practice or clinic.
47. Dentist's license number: Refers to the license number of the billing dentist. This may differ from that of the treating dentist which appears in the Dentist's signature block (62).
48. First visit date current series: Necessary to determine what services are covered when a patient becomes eligible in the middle of an active treatment plan.
49. Place of treatment: Necessary to determine if medical and/or hospital coverage including dental benefits may be activated. ECF stands for "extended care facility."
53. Radiographs or models enclosed: Complete when diagnostic materials are submitted.
54. Is treatment for orthodontics? Necessary to determine the prorated benefit.
55. If prosthesis is for a crown, bridge or denture, is this initial placement? Determines eligibility and liability.
56. Is treatment result of occupational illness or injury? Refers to possible application of Worker's Compensation, which would alter coverage available and carrier involved.
57. Is treatment result of auto accident? Necessary to determine reimbursement in no-fault automobile accident cases. Indicates whether another party's insurance may be responsible. Important for COB.
58. Diagnosis Code Index: When reporting the diagnoses for treatment, refer to the ADA's SNODENT diagnostic codes (available in the year 2000). Record the 5-digit diagnoses code(s) in spaces 1-8, as necessary. The submitter should record the 5-digit diagnosis codes on line 1 through 8. In box 59, the numbers 1-8 would be entered under the diagnosis index # column.
59. Examination and treatment plan: Use the American Dental Association's *Current Dental Terminology (CDT-3)* for appropriate procedure codes. If a procedure is performed multiple times, record the procedure code once and the frequency in the quantity (Qty) column. When completing the diagnosis index # column, enter the index # (1-8) for as many diagnoses as necessary for each procedure code. When a patient has more than one diagnoses per procedure, separate index number with comma.
60. Identify all missing teeth with "x".
61. Remarks for unusual services: Use to indicate any information that you feel may be helpful in determining the benefits for the treatment.
62. Dentist's signature block: The treating dentist's signature and license number. Dentists should be aware that they may have ethical and legal obligations to refund fees for services that are paid in advance but not completed.

63-66. Address where treatment was performed: Necessary if the treatment was performed at a different location than indicated in boxes #46,50-52.

For administrative use only: Area where carrier calculates benefits.

Payment itemization: The spaces under "payment by other plan" will be completed by the carrier and may vary from carrier to carrier.

New Rule, R.2001 d.364, effective October 1, 2001.
See: 33 N.J.R. 750(a), 33 N.J.R. 3461(a).
Administrative correction.
See: 39 N.J.R. 1739(a).

SUBCHAPTER 4. ORGANIZED DELIVERY SYSTEMS

11:22-4.1 Purpose and scope

(a) This subchapter sets forth the filing and requirements for an entity to be licensed as an organized delivery system pursuant to N.J.S.A. 17:48H-1 et seq.

(b) This subchapter applies to any entity seeking to become licensed as an organized delivery system pursuant to N.J.S.A. 17:48H-1 et seq.; or an existing organized delivery system required to obtain a license to operate pursuant to N.J.S.A. 17:48H-11. A non-exhaustive list of examples of entities and arrangements that are subject to these rules is set forth in Exhibit B in the Appendix to this subchapter, incorporated herein by reference.

11:22-4.2 Definitions

The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

"Affiliate" means a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the organized delivery system.

"Capitation" means a fixed per member, per month, payment or percentage of premium payment for which the provider assumes the risk for the cost of contracted services without regard to the type, value or frequency of the services provided.

"Carrier" means an insurer authorized to transact the business of health insurance as defined at N.J.S.A. 17B:17-4, a hospital service corporation authorized to transact business in accordance with N.J.S.A. 17:48-1 et seq., a medical service corporation authorized to transact business in accordance with N.J.S.A. 17:48A-1 et seq., a health service corporation authorized to transact business in accordance with N.J.S.A. 17:48E-1 et seq. or a health maintenance organization authorized to transact business pursuant to N.J.S.A. 26:2J-1 et seq.

"Certified organized delivery system" means an organized delivery system that is compensated on a basis which does not entail the assumption of more than de minimis financial risk by the organized delivery system and that is certified by the DHSS in accordance with N.J.S.A. 17:48H-1 et seq.

"Commissioner" means the Commissioner of the New Jersey Department of Banking and Insurance.

"Comprehensive health care services" means the basic benefits provided under a health benefits plan, including medical and surgical services provided by licensed health care providers who may include, but are not limited to, family physicians, internists, cardiologists, psychiatrists, rheumatologists, dermatologists, orthopedists, obstetricians, gynecologists, neurologists, endocrinologists, radiologists, nephrologists, emergency services physicians, ophthalmologists, pediatricians, pathologists, general surgeons, osteopathic physicians, physical therapists and chiropractors. Basic benefits may also include inpatient or outpatient services rendered at a licensed hospital, covered services performed at an ambulatory surgical facility and ambulance services.

"Consumer Price Index" means the medical component of the Consumer Price Index for all Urban Consumers, as reported by the United States Department of Labor, shown as the average index for New York-Northern New Jersey-Long Island region and the Philadelphia-Wilmington-Trenton-region combined as published by the Commissioner in the New Jersey Register.

"Department" means the New Jersey Department of Banking and Insurance.

"DHSS" means the New Jersey Department of Health and Senior Services.

"Financial risk" means exposure to financial loss that is attributable to the liability of an organized delivery system for the payment of claims or other losses arising from covered benefits for treatment or health care services other than those performed directly by the person or organized delivery system liable for payment, including a loss sharing arrangement. A payment method wherein a provider accepts reimbursement in the form of a capitation payment for which it undertakes to provide health care services on a prepayment basis shall not per se be considered financial risk. A financial risk shall exist if, under an agreement between the organized delivery system and the carrier, the financial obligations of the organized delivery system for payment of benefits or for providing treatment or health care services does or potentially may exceed any payments that may be received from the carrier. Financial obligation shall include the attendant administrative costs related to providing the treatment or services.

"Health benefits plan" means a benefits plan which pays or provides hospital and medical expense benefits for covered services, and is delivered or issued for delivery in this State by or through a carrier. Health benefits plan includes, but is not limited to, Medicare supplement coverage and risk contracts to the extent not otherwise prohibited by Federal law. For the purposes of this subchapter, health benefits plan shall not include the following plans, policies or contracts: accident only, credit, disability, long-term care, CHAMPUS supplement coverage, coverage arising out of a workers' compensation or similar law, automobile medical payment insurance, personal injury protection insurance issued pursuant to N.J.S.A. 39:6A-1 et seq. or hospital confinement indemnity coverage.